## NEW YORK STATE DEPARTMENT OF HEALTH

**Bureau of Emergency Medical Services** 

## EMT-Paramedic RECERTIFICATION FORM

**Continuing Education Recertification Program** 

| ENT Number  Social Security Number  Last Name  First Name  MI  Address  City  State  Zip Code  Enter Agency Code of Your Participating Agency  Enter Agency Code of Your Participating Agency  I affirm that in accordance with the requirements of 10NYCRR Part 800.8(e), I have not been convicted of or am not currently charged with any misdemeanors or febories: I understand that if I have a conviction it will be individually reviewed and that any such conviction may not be an automatic bar to certification. The Department of Health will determine if the conviction is applicable under the previsions of 10NYCRR Part 800.  Printed Name of Instructor I hereby verify that the participant has satisfactorily completed and shows competence in: Adult, Child and Infant 18.2 rescuer CPR an Obstructed Airway management  *A COPY OF THE CARD ISSUED MUST ACCOMPANY THIS APPLICATION IF THE INSTRUCTOR DOES NOT SIGN*  ACLS Certification  *A Copy of Current Card (front and back) MUST Accompany This Application*  | Print Neatly in UPPER CASE Letters -   | Please Complete ALL Information – Incomplete forms will be denied and returned                                   |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
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|  |  | ·  |  |  |  |  |  |  |

**DOH-4231 (7/03)** 1 of 2

| EMT-Paramedic Refresher Training - 48H   | ours      |             |   |             |           |             |                       |  |
|--|-----------|-------------|---|-------------|-----------|-------------|-----------------------|--|
| Торіс  |           |             |   |             |           |             | Hours<br>Earned       |  |
| Preparatory  |           |             |   |             |           |             |                       |  |
| Airway Management & Ventilation  |           |             |   |             |           |             |                       |  |
| Trauma   |           |             |   |             |           |             |                       |  |
| Medical (see sub categories)   |           |             |   |             |           |             |                       |  |
| Pulmonary and Cardiology   |           |             |   |             |           |             |                       |  |
| Neurology/Endocrinology/Allergies & Anaphylaxis  |           |             |   |             |           |             |                       |  |
| Gastroentaerology/Renal & Urology/Toxicology/Hematology  |           |             |   |             |           |             |                       |  |
| Environmental Conditions/Infectious & Communicable Diseases/Behavioral   |           |             |   |             |           |             |                       |  |
| Gynecology and Obstetrics  |           |             |   |             |           |             |                       |  |
| Special Considerations (see sub categories)  |           |             |   |             |           |             |                       |  |
| Neonatology and Pediatrics   |           |             |   |             |           |             |                       |  |
| Abuse and Assault  |           |             |   |             |           |             |                       |  |
| Patients w/Special Challenges and Acute Interventions for Chronic Care Patients  |           |             |   |             |           |             |                       |  |
| Operations   |           |             |   |             |           |             |                       |  |
| TOTALS   |           |             |   |             |           |             |                       |  |
| Additional 24 Hours of Continuing Educa  | tion – Mı | ıst includ  | de mandatory training in Geria                  | trics an    | d WI      | MD as       | noted!                |  |
| Topic  | Hours     | Date        | Topic   |             |           | lours       | Date                  |  |
| Geriatrics – 3 hours minimum   | Hours     | Date        | Торіс   |             |           | iours       | Date                  |  |
| WMD/Terrorism – 3 hours minimum  |           |             |   |             |           |             |                       |  |
|  |           |             |   |             |           |             |                       |  |
|  |           |             |   |             |           |             |                       |  |
|  |           |             |   |             |           |             |                       |  |
|  |           |             |   |             |           |             |                       |  |
| Skill Competency Verification  |           |             |   |             |           |             |                       |  |
| Skill  |           |             |   |             | QA<br>/QI |             | Direct<br>Observation |  |
| Patient Assessment (Medical and Trauma)  |           |             |   |             |           |             |                       |  |
| Airway/Ventilation (Simple Adjuncts, Advanced Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask – one and two rescuer)  |           |             |   |             |           |             |                       |  |
| Cardiac Arrest Management (Therapeutic Modalities, Megacode, Monitor/Defibrillator Knowledge   |           |             |   |             |           |             |                       |  |
| Hemorrhage Control & Splinting (long bone injury, joint injury, and traction splinting)  |           |             |   |             |           |             |                       |  |
| IV Therapy / Medication Administration Spinal Immobilization (Seated and Supine)   |           |             |   |             |           |             |                       |  |
| As the Physician Medical Director for the Participant's Coabove.   | ,         | ucation Pro | gram I hereby affix my signature attestin       | g to profic | ciency    | in all skil | ls outlined           |  |
|  |           |             |   |             |           |             |                       |  |
| Printed Name of Medical Director Signature of Medical Director Date  |           |             |   |             |           |             |                       |  |
| I hereby affirm that all statements on this recertification form are true and correct, including all copies of cards, certificates and other required verification. It is understood that false statements or documents submitted with the intent to falsely recertify may be grounds for revocation of certification and applicable civil and criminal penalties. It is also understood that the Bureau of Emergency Medical Services or its designee may conduct an audit of the activities listed herein at any time. This form must be mailed and postmarked no less than 45 days prior to your current expiration date! |           |             |   |             |           |             |                       |  |
| Signature of Participant   |           | Signa       | ture of Sponsoring Agency Contact / Coordinator |             |           |             |                       |  |

**DOH-4231 (7/03)** 2 of 2

Date

Date